ECONOMICS AND URBAN HEALTH

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Major American cities are a crucible in which all the elements that afflict the nation's health care system are combined and intensified. Large cities have high concentrations of poverty, high unemployment, large numbers of uninsured families, significant minority populations (including large numbers of documented and undocumented immigrants), and fiscally strapped public hospital and clinic systems. In these environments, Medicaid is a major source of funding health care for low-income populations and helps ensure the economic viability of urban safety net hospitals that serve the poor and uninsured.

Managed care is rapidly transforming health care in urban environments. Driven initially by employers concerned with the cost of employee health benefits, government programs such as Medicaid and Medicare are also increasingly turning to managed care as a way of setting limits on expenditure growth. Very little is known about the consequences of these trends for those who are most vulnerable—poor and seriously ill people and the institutions that have historically served low-income communities.

The policy dilemmas facing urban health leaders include:

1. Should a public health and hospital system be maintained, restructured, and improved to be an effective competitor in a managed-care marketplace, or should public dollars be used to finance the health care of disadvantaged populations in the private health care system?
2. Since insurance coverage is vital in the health care marketplace, how can coverage of the uninsured best be expanded—through Medicaid or new programs?
3. How can hard-to-reach populations, including minority and immigrant groups, be served most effectively?

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4. How can dollars currently in the health care system be more effectively deployed to improve health and meet the health care needs of all urban residents?
5. What are potential sources of financing improved health care for uninsured and low-income families?

THE ECONOMICS OF URBAN HEALTH

While 14% of all Americans under age 65 live in poverty, one-fourth of the nonelderly in New York City have incomes below the federal poverty level. Los Angeles has a similar minority and immigrant population and a similar ratio (23%) of residents living below the poverty level (Fig. 1). Half the population under age 65 in both cities have incomes below 250% of poverty. The proportion of poor residents in other large cities hovers close to the national average, yet the federal poverty income threshold does not adjust for geographic differences in the cost of living. Since large cities tend to have high housing costs, these rates understate the extent of financial deprivation faced by low-income families.

Large cities also have an employment pattern different from other parts of the country. Their economies are more dependent on service and retail trades and less dependent on manufacturing. Entertainment and the arts, financial services, advertising, media, educational institutions, health care and health insurance industries, and international corporate headquarters form much more of

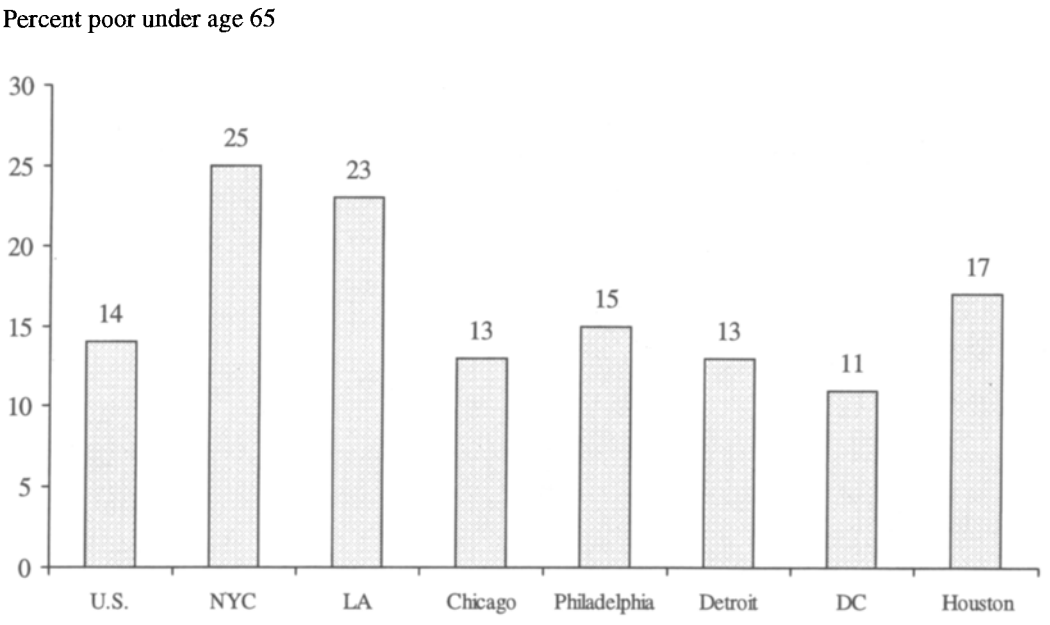

FIG. 1 Poverty in major American cities, 1996. *Source*: Analyses of March 1997 Current Population Survey by UCLA Center for Health Policy Research.

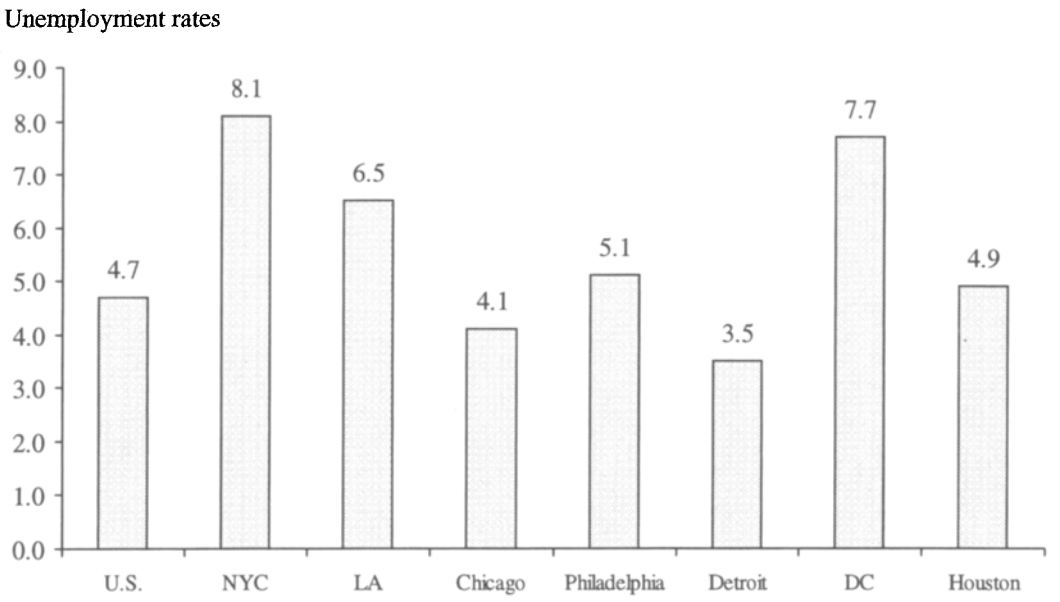

FIG. 2 Unemployment in major American cities, September 1997. *Source*: Bureau of Labor Statistics, 1997.

the employment base in New York City and Los Angeles, for example, than elsewhere in the country.

Local industries and employment rates have three major implications for health care. First, a combination of demand and supply factors, such as the high cost of doing business in urban environments and large immigrant populations, can lead to high unemployment. Both New York City and Los Angeles currently have very high rates of unemployment—8.1% and 6.5%, respectively, compared with a national average of 4.7%. In fact, five of the seven largest cities in the country have rates higher than this average (Fig. 2).

Second, while some of the predominately large-city industries provide high-wage jobs with good health benefits, others are characterized by low-wage and part-time jobs that do not offer health insurance coverage for workers and their families.[1] Service and retail trades, in particular, are much less likely to provide health benefits, which contributes to high rates of uninsured populations.

Third, while urban centers have disproportionate rates of poverty and uninsured populations, the ability to raise local revenues through taxes to support services to needy populations is constrained by a concern for losing industry, jobs, and higher income families to surrounding or more distant municipal jurisdictions.

These pressures put a premium on innovative approaches to redeploying existing resources more efficiently and equitably to serve the health needs of the

entire urban population. In the past, higher charges to privately insured patients helped cross subsidize free or low-cost care to the uninsured. In the future, placing surcharges on managed-care plans or health care providers to establish a fund for financing care for low-income families may be required. A major case can also be made for federal financing of health care for those who cannot afford coverage to avoid placing undue fiscal pressure on local municipalities.

The Uninsured

In 1996, 41.4 million Americans were uninsured, including about 18% of the population under age 65.[2] Urban areas are more likely than others to have large uninsured populations: an average of 27% of New York City's population under the age of 65 is uninsured, and Los Angeles and Houston average 30% or above—more than 50% higher than the national average (Fig. 3).

The characteristics of the uninsured are relatively well known. Three in five have low incomes (below 200% of poverty), and 85% are in families headed by working people. The uninsured also include a high percentage of children, workers in small companies, early retirees, and single individuals or individuals in single-parent households. Only 3% are uninsured for health reasons.[3]

Recent research has shown that, while 26% of low-income urban adults (below 250% of poverty) are uninsured, another 17% have not had health insurance coverage at some time in the last two years (Fig. 4). Many of these individuals

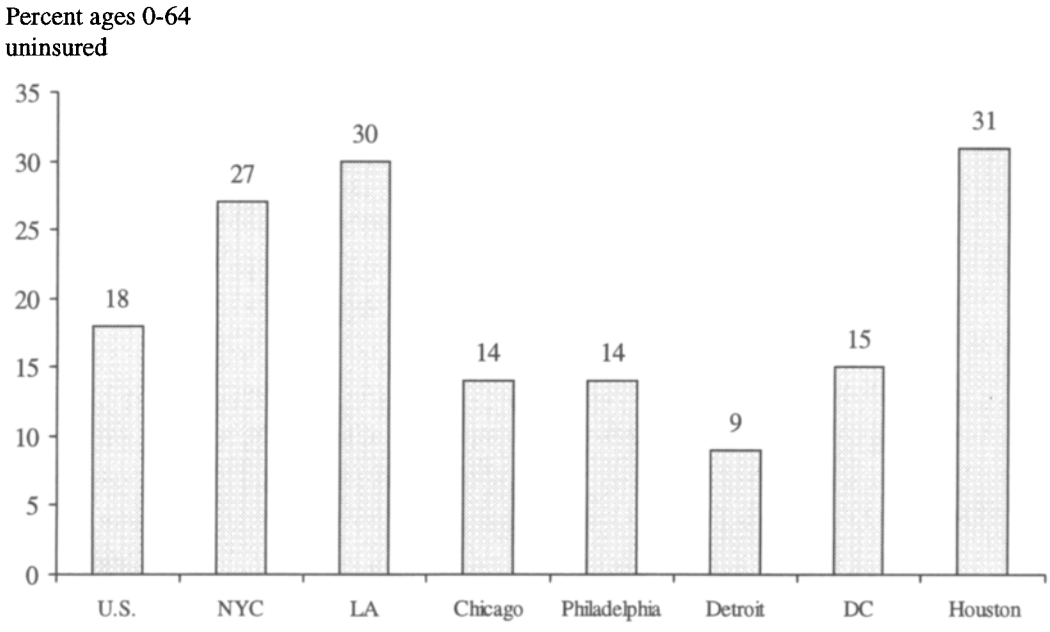

FIG. 3 Uninsured in major American cities, 1996. *Source*: Analyses of March 1997 Current Population Survey by UCLA Center for Health Policy Research.

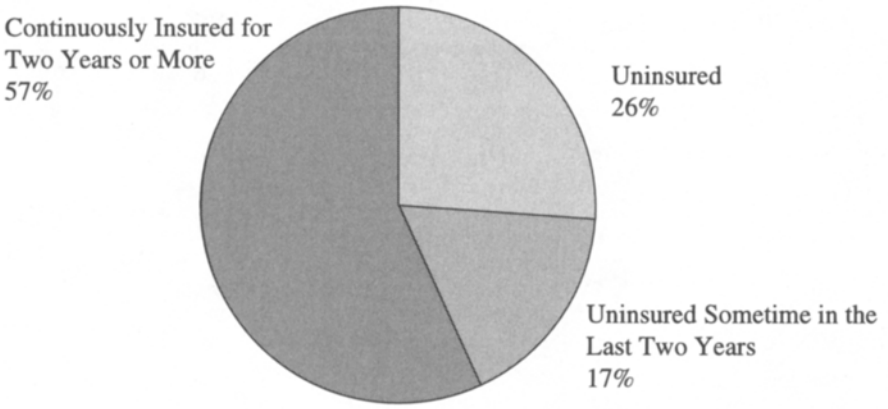

FIG. 4 Intermittent health insurance coverage of low-income (below 250% of poverty) urban residents in Florida, Minnesota, Oregon, Tennessee, and Texas, 1995–1996. *Source*: Kaiser/Commonwealth Fund Five State Low Income Survey, 1995–1996.

have had lengthy gaps in coverage; in fact, 51% have had gaps of one year or longer.

The Importance of Medicaid

The ranks of the uninsured would be even larger were it not for Medicaid, which covers 59% of poor people under age 65. A recent analysis of low-income urban residents of five states—Florida, Minnesota, Oregon, Tennessee, and Texas—found that 26% of those with incomes below 250% of the federal poverty level were uninsured. Another 24% were covered by Medicaid, and most of the remaining half of low-income adults were covered by private health insurance plans (Fig. 5). Without Medicaid, fully one-half of low-income urban residents could be uninsured.

States that have expanded Medicaid coverage to cover low-income adults without regard to welfare eligibility, work status, or family composition have been remarkably successful at reducing the numbers of uninsured.[4] These expansions have not resulted in a "crowding out" of private health insurance coverage, which has remained remarkably constant across states regardless of the extent of Medicaid coverage of low-income adults.

Medicaid is particularly crucial to the coverage of poor pregnant women and children: 76% of pregnant women and infants are covered by the program, as are 79% of poor children aged 1 to 5, 71% of poor children aged 6 to 12, and 56% of poor children aged 13 to 18.[5] Mothers of poor children, however, are not as well covered by Medicaid. Nearly a third of poor and near-poor women are uninsured.[6] One-fourth of all non-elderly women who enroll in Medicaid do so because of pregnancy, but their coverage continues after the child's birth only if the woman meets more restrictive eligibility standards. Fifteen percent of

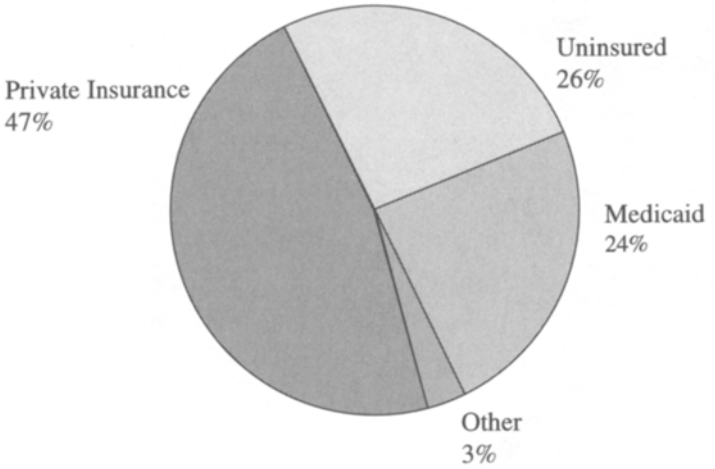

FIG. 5 Sources of insurance for low-income (below 250% of poverty) urban residents in Florida, Minnesota, Oregon, Tennessee, and Texas, 1995–1996. *Source*: Kaiser/Commonwealth Fund Five State Low Income Survey, 1995–1996.

women leave Medicaid because they become ineligible after childbirth,[6] and two-thirds of women who leave Medicaid for all reasons become uninsured.

Medicaid typically does not cover men, childless couples, or older adults (aged 45–64) who do not yet qualify for Medicare unless they do so because of low incomes or disabilities. Unemployed people and early retirees are at high risk of being uninsured and often cannot afford to buy their own health insurance

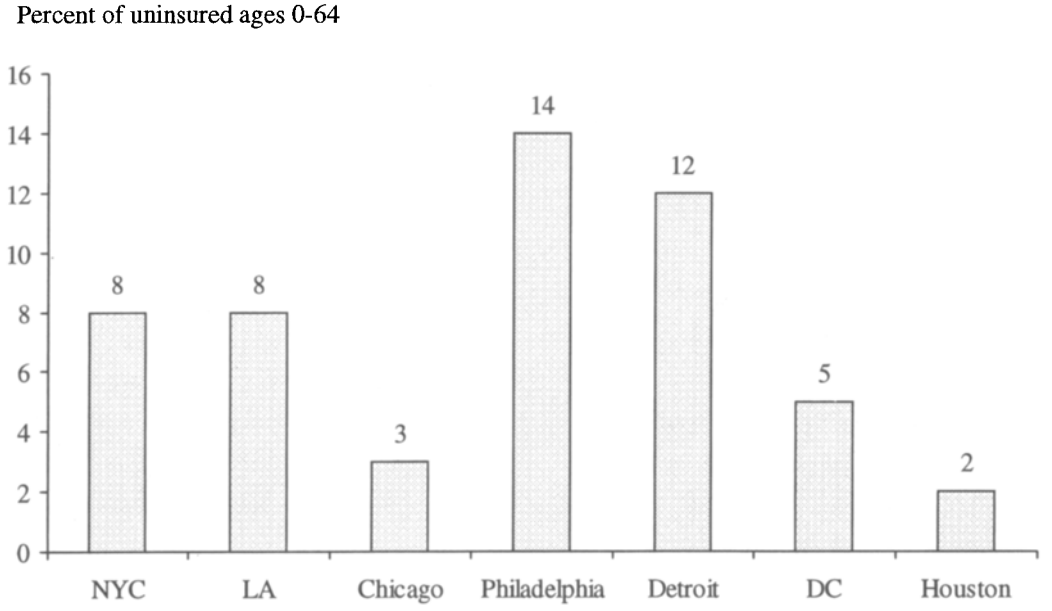

FIG. 6 Uninsured are unable to obtain care when needed, 1994. *Source*: Analyses of 1994 National Health Interview Survey by UCLA Center for Health Policy Research.

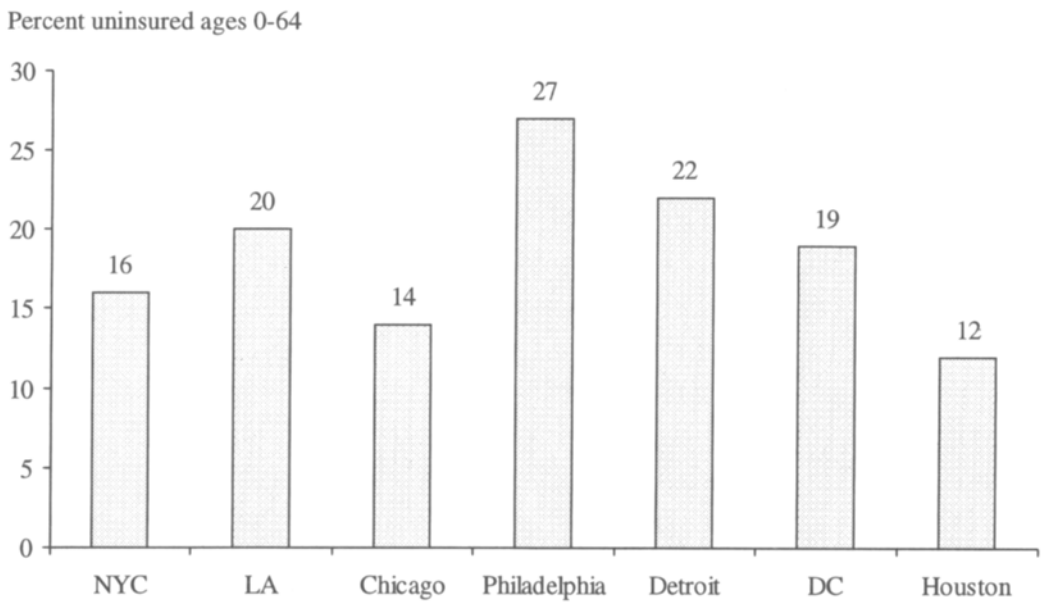

FIG. 7 Uninsured with delayed care due to cost, 1994. *Source*: Analyses of 1994 National Health Interview Survey by UCLA Center for Health Policy Research.

on the open market. Only one in five people who are eligible to extend their employer coverage under COBRA (Comprehensive Omnibus Budget Reconciliation Act) provisions do so, largely because they cannot afford to do so.[7]

Access to Care

The consequences of being uninsured include failure to get preventive care, inadequate maintenance of chronic conditions, incidence of preventable hospitalizations, and lack of a regular source of continuing care.[8] Studies have documented the link between being uninsured and poorer health outcomes for breast cancer, ruptured appendix, asthma, diabetes, and overall mortality.[8]

The myth that people who are uninsured and need care somehow manage to obtain care has never been true and is less likely to be true in the future.[9] Almost 1 in 10 of the uninsured in New York City and Los Angeles have been unable to obtain medical care when they needed it, and even higher percentages in Philadelphia and Detroit have not gotten needed care (Fig. 6). Even larger percentages of the uninsured in large cities delayed getting medical care because they could not afford it (Fig. 7).

The uninsured and those with gaps in coverage also differ from the insured in terms of their sources of care. In the nation's seven largest cities, one-third or more of the uninsured have no regular source of medical care; in Los Angeles, almost half of uninsured people have this problem (Fig. 8). The uninsured are less likely than the continuously insured to receive care in a physician's office

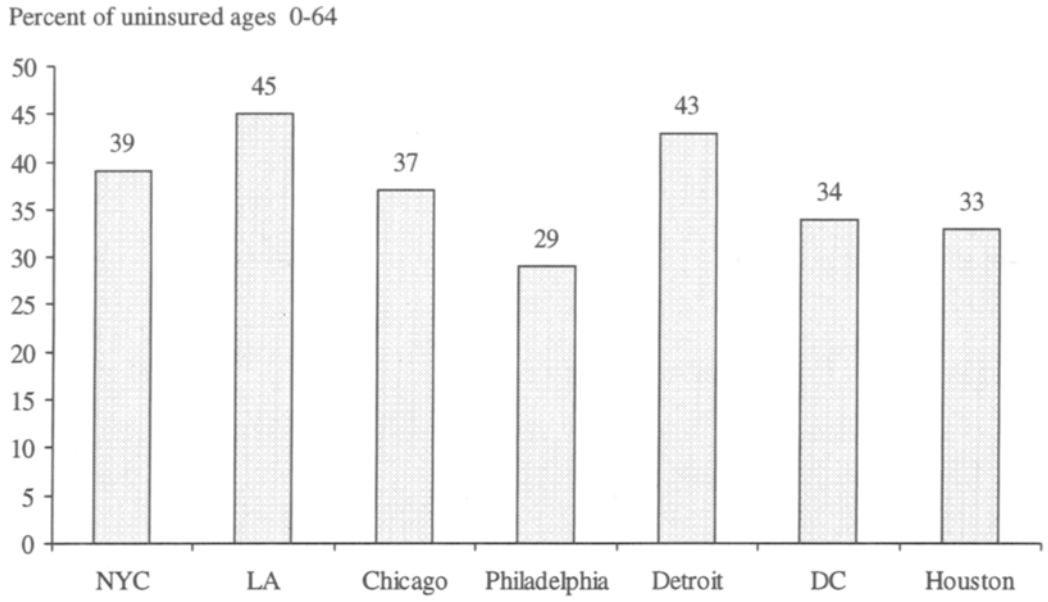

FIG. 8 Uninsured with no regular source of medical care, 1994. *Source*: Analyses of 1994 National Health Interview Survey by UCLA Center for Health Policy Research.

and are more than twice as likely to receive care in an emergency room. The experiences of the insured with gaps in coverage lie in the middle of these two groups (Fig. 9).

Quality of care as perceived by patients is also different for the insured and the uninsured. For urban residents in five states, 31% of the uninsured rated the

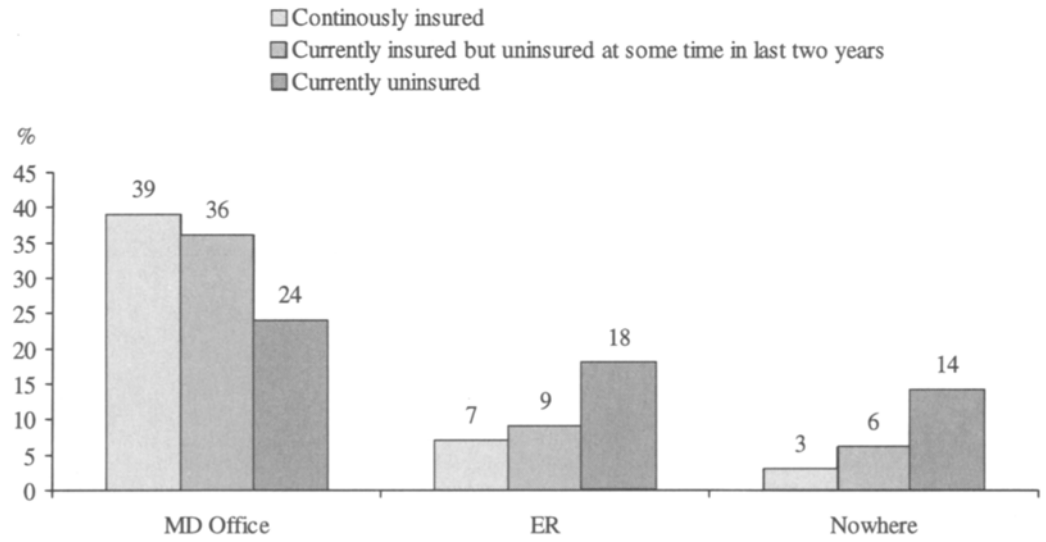

FIG. 9 Places of care by insurance status of low-income (below 250% of poverty) urban residents in Florida, Minnesota, Oregon, Tennessee, and Texas, 1995–1996. *Source*: Kaiser/Commonwealth Fund Five State Low Income Survey, 1995–1996.

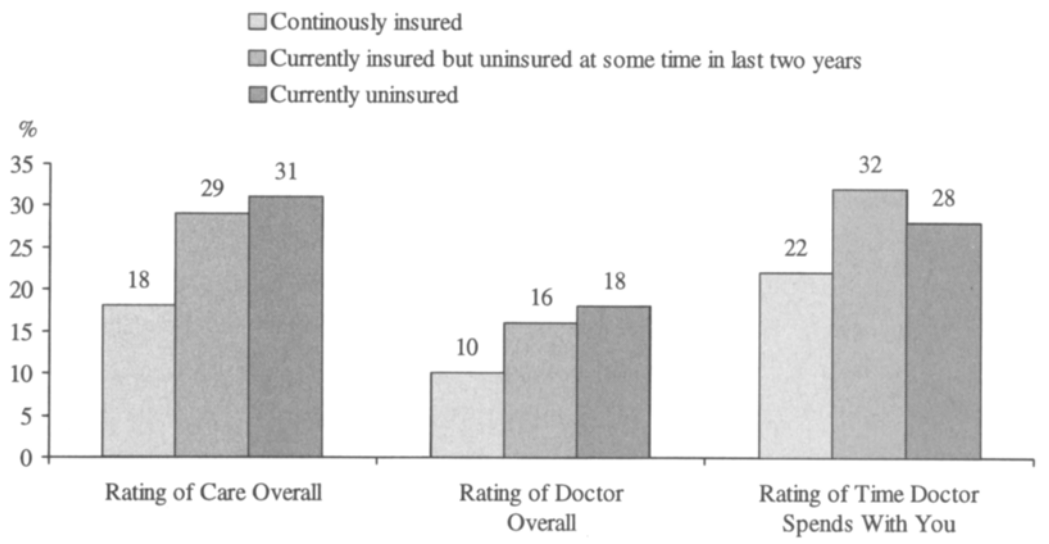

FIG. 10 Care experiences rated "poor" or "fair," according to length of health insurance coverage of low-income (below 250% of poverty) urban residents in Florida, Minnesota, Oregon, Tennessee, and Texas, 1995–1996. *Source*: Kaiser/Commonwealth Fund Five State Low Income Survey, 1995–1996.

care they received as fair or poor, compared with 18% of those who had been insured throughout the previous two years (Fig. 10). For those who had been recently uninsured, 29% rated their care as fair or poor. Similarly, the uninsured were more likely to rate their doctor as fair or poor (18%) than those who had been continuously insured (10%). Time spent with a doctor was also viewed as unsatisfactory by the uninsured to a greater extent than by the insured: more than one-fourth of the uninsured (28%) rated "time doctor spends with you" as fair or poor, compared with 22% of the continuously insured.

These differences across groups and across major cities are thought provoking, but at present, there is little research to help understand the reasons behind them. Such analysis to determine the difference that Medicaid coverage, managed care, and public hospitals make in high-risk populations' ability to obtain needed care should be a high priority. Monitoring the fate of public hospitals and community health centers as market changes divert revenues from traditional Medicaid providers is also important. If, as seems likely, safety net health care providers undergo increased financial difficulties, their ability to serve the uninsured may be curtailed.

Medicaid Managed Care

Fiscal pressures on safety net providers are exacerbated by the rapid movement toward Medicaid managed care by state and city governments that seek to control costs.[10] Waivers have permitted some states to enroll beneficiaries mandatorily

into managed-care plans, and other states have encouraged marketing by managed-care plans to Medicaid beneficiaries. As a result, enrollment in the program has grown rapidly: from 1991 to 1995, the proportion of beneficiaries enrolled in managed care tripled, going from 10% to 30%. In 1996, more than 13 million Medicaid beneficiaries, or 40% of total Medicaid enrollment, were in managed-care plans.[11]

The cost, quality, and access implications of this move to Medicaid managed care are sketchy.[12] Much of the research is based on old data and old plans, while the character and composition of the managed-care industry has changed markedly in recent years. Today, most Medicaid managed-care enrollees are mothers and children, as the majority of states have not yet moved their aged and disabled Medicaid beneficiaries into managed-care plans. Research has shown that Medicaid beneficiaries in New York City who have voluntarily enrolled in managed care are healthier than those who remain in fee-for-service arrangements.[13] Meeting the needs of beneficiaries with extensive health problems will be a major challenge as the city makes the transition to mandatory managed-care enrollment, and monitoring and evaluating the impact of the shift will be extremely important.

Examining the continuity of care for urban low-income populations will also be important. Medicaid coverage is often short term (28% of non-elderly women are covered for one year or less),[6] and poor and near-poor people move on and off the program as they get or lose a job, become pregnant or have a child, and get married or divorced. Continuity of care is often lost when beneficiaries lose and gain eligibility, because they must often change plans or physicians with new enrollment.

POLICY IMPLICATIONS

The stress points within the US health care system are fully exposed within the nation's largest cities. Substantial proportions of urban residents are living in poverty and do not have health insurance, even when they are in working families. These individuals face numerous barriers to accessing needed medical care and are confronted with large cost burdens when they do receive care. In addition, many urban residents experience lengthy interruptions in insurance coverage, which threatens the quality and continuity of their care. Substantial minority and immigrant populations, which have a disproportionate share of low incomes and lack of insurance, face additional problems accessing care that is culturally competent and that recognizes the heterogeneous nature of urban communities.

Safety Net Providers

Set against such challenges, the crucial role of safety net providers is even more apparent. Public hospitals and major teaching hospitals need financial and political support to become more efficient and competitive as the health care landscape is reshaped by managed care. Policy makers can assist these providers in preserving their ability to serve the uninsured; creative approaches in Hawaii and Washington, for example, contain provisions that are favorable to Medicaid managed-care plans owned and operated by community health centers.[14] Strategies such as automatic enrollment formulas should be encouraged, to strengthen providers who care for uninsured and underserved populations.

Medicaid

Preserving and strengthening Medicaid is also critical to ensuring access to medical care for urban populations. Welfare reform legislation retained eligibility for Medicaid for most women on welfare and their children, but vigilance is required to ensure that eligible mothers and children are enrolled. Because the legislation did affect coverage for legal immigrants, institutions that serve large immigrant populations may face increased financial burdens.

As Medicaid managed care continues to grow, it will be necessary to ensure that beneficiaries have the right to remain in traditional Medicaid or to choose among managed-care plans. In addition, managed-care plans should be subject to minimum quality standards and to accreditation. Information on plans' performance should be collected and made available, including such measures as the National Committee for Quality Assurance's HEDIS indicators and survey data on patient experiences from the federal Consumer Assessment of Health Plan Surveys. Special efforts should be made to ensure that the information is truly accessible to beneficiaries through person-to-person contact in a language and context that is sensitive to beneficiaries' cultural and educational diversity.

Expansion of Health Insurance Coverage

Holding the ground on loss of health insurance for low-income people, however, is a hollow victory in the face of ongoing erosion of health insurance coverage under employer plans. The nation should address seriously incremental approaches to expanding health insurance coverage for low-income people.[15] Building on existing programs and administrative structures offers a foundation for such incremental expansions.

The recently enacted State Children's Health Insurance Program (SCHIP) provides an opportunity for states to expand coverage to low-income children in families with incomes up to twice the federal poverty level. This legislation

has the promise of extending coverage to more than 2 million uninsured children and is a top priority for action. Consideration should be given to expanding such coverage to parents, both because of the serious need for such coverage to ensure access to care and because the health of parents and children are linked. Maternal depression, for example, is a major deterrent to the healthy development of children.[16]

The children's health legislation sets a precedent for combined federal and state financing for expanding coverage to the uninsured. Federal matching rates vary across states, but average about 70%, with states contributing the balance of funding. Federal and state financing makes more sense than expecting individual cities to bear the burden of financing health care for the poor and near poor. A federal-state system broadens the tax base that supports coverage and eliminates the concern individual municipalities have about loss of industry and jobs to surrounding jurisdictions.

The major fiscal strategy for large cities to pursue in the absence of federal and state fiscal responsibility is to try to redeploy resources currently within the health care system to ensure access to care for all. In the past, some state governments have created pools for financing care for the indigent by assessing surcharges on all hospitals to reimburse those that care for the uninsured. This concept could be extended to managed-care plans by assessing surcharges on all plan revenues to subsidize the purchase of coverage for the uninsured.

The nation, and large American cities, in particular, cannot afford to continue to ignore the growing number of uninsured residents. The evolution of the health care marketplace will make it increasingly difficult for the uninsured to obtain free or subsidized care. Those safety net institutions—whether they be public or nonprofit hospitals and health centers—that continue to serve those who cannot pay will come under increasing financial strain as the burden of caring for the uninsured and underinsured is concentrated in fewer institutions. Until all residents have access to health care that is affordable and of high quality, the promise of America's cities as centers of opportunity will remain unfulfilled.

REFERENCES

1. Gabel JR, Ginsburg PB, Hunt KA. Small employers and their health benefits, 1988–1996: an awkward adolescence. *Health Aff.* September/October 1997;16:103–110.
2. Employee Benefit Research Institute. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey, December 1997.* Washington, DC: EBRI Issue Brief No. 192; December 1997.
3. Davis K, Rowland D, Altman D, Scott Collins K, Morris C. Health insurance: the size and shape of the problem. *Inquiry.* Summer 1995;32:196–203.
4. Schoen C, Lyons B, Rowland D, Davis K, Puleo E. Insurance matters for low-income adults: results from a five-state survey. *Health Aff.* September/October 1997;16:163–171.
5. Holahan J. *Expanding Insurance Coverage for Children.* Washington, DC: The Urban Institute; May 1997.

6. Short PF. Medicaid's role in insuring low-income women. [Based on analysis of the 1990 panel of the Survey of Income and Program Participation of non-elderly women with incomes below 200% of poverty.] New York: Commonwealth Fund; May 1996.
7. Claxton G, Levitt L. Reform of the individual health insurance market. New York: Commonwealth Fund; August 1996.
8. Davis K. Uninsured in an era of managed care. *Health Serv Res.* February 1997;31: 641–649.
9. Schroeder SA. The medically uninsured—will they always be with us? *N Engl J Med.* April 25, 1996;334:1130–1133.
10. Siegel B. Public hospitals—a prescription for survival. New York: Commonwealth Fund; October 1996.
11. US Department of Health and Human Services, Health Care Financing Administration, Office of Managed Care. *Medicaid Managed Care Enrollment Report.* Washington, DC: US Government Printing Office; June 1996.
12. Rowland D, Rosenbaum R, Simon L, Chait DE. Medicaid and managed care: lessons from the literature. [Report of the Kaiser Commission on the Future of Medicaid, March 1995.]
13. Sisk J. Evaluation of Medicaid managed care: satisfaction, access, and use. *JAMA.* July 3, 1996;276:50–55.
14. Lesser C, Duke K, Luft H. Care for the uninsured and underserved in the age of managed care. New York: Commonwealth Fund; March 1997.
15. Davis K, Schoen C. Incremental health insurance coverage: building on the current system. In: Altman SH, Reinhardt UE, Shields AE, eds. *Who Will Care for the Poor and Uninsured?* New York: Health Administration Press; 1997.
16. Young KT, Davis K, Schoen C. *The Commonwealth Fund Survey of Parents with Young Children, August 1996.*